

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009220

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2423

FILED MAR 8 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 924 Allen	

3. NAME OF DECEASED (Type or print) First Middle Last HOWARD POULSON		4. DATE OF DEATH Month Day Year 3 1 63	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/12/05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) DeSoto, Ill.
13a. FATHER'S NAME Sell Poulson		13b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of war) yes W.W. II		17. INFORMANT Lorine Poulson, 924 Allen	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory asphyxiation DUE TO (b) Circumferential DUE TO (c) & Pneumonia		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4/6/3X		PART III. If deceased was female: was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION		COUNTY STATE

21. I attended the deceased from 2-17-63 to 3-1-63 and last saw her alive on 3-1-63	
Death occurred at 9:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Thomas J. Kilson MD	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 3-1-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/5/63	23c. NAME OF CEMETERY OR CREMATORY National Cemetery
23d. LOCATION (City, town, or county) Jefferson Barracks, Mo.		24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette
25. DATE RECD. BY LOCAL REG. MAR 4 1963		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RATE AMENDED

VS 300
Rev. 4/59

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75

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.